SYSTEM FINANCE
VISION SUBCOMMITTEE #1

Goal:

Establish stable system financing based on value of service.

Findings:

After several years of development, in August 1996, the National Highway Traffic Safety Administration published "EMS Agenda for the Future". One of the 14 EMS Attributes identified as critical for development was System Finance. The opening paragraph of that section states "Emergency medical services systems, similar to all public and private organizations, must be financially viable. In an environment of constant economic flux, it is critical to continuously strive for a solid financial foundation".

In the past 10 years, California has become a case study for this particular "Agenda" finding. In California, as in much of the nation, the primary purpose for EMS funding continues to be the maintenance of an EMS system of resources standing by and prepared to respond to medical emergencies at a certain desired level or benchmark of performance. The primary source of funding for this "readiness" continues to be for transportation and services rendered during transportation. This misalignment of funding needs and sources is at the heart of over a decade of legal, regulatory and legislative conflicts.

The task accepted by this group was to move past the recognition of this condition and develop recommendations to move toward a stable financing structure which is capable of reimbursing participants according to the incremental value of their services.

Background:

In 1997 the California State EMS Commission undertook the current Vision process and established 8 committees**,** each with a Commission Lead**,** to generate consensus recommendations for changes to California's EMS System.

This particular committee decided to structure the problem by dividing it into functional areas and then split into what would ultimately be 8 "focus" or subgroups. Those groups are; Personnel and Training, Administration and System Evaluation, Prevention and Education, Dispatch and Communications, First Responder and Medical Transportation, Medical Facilities, Disaster and Medical Mutual Aid, and Poison Control.

Each of these groups was to deal with the specific financial aspects of its designated EMS System function. Each subgroup researched and worked separately**;** and periodically the entire

committee met to share progress and collaborate on the product. Most groups developed a matrix in order to briefly outline the existing or current financial status of each of these functional areas. Then a desired or future matrix was developed. From these matrices, a narrative set of recommendations for action were developed.

The overall recommendations are listed below. The various matrices and accompanying narratives are included in the detail section that follows.

Recommendations:

This is a list of individual recommendations directed at identifying all the major components necessary to achieve the goal. Each of these recommendations is expressed as a positive action or change. These recommendations are arranged by each focus group's functional title.

Personnel and Training

1. Develop a multidisciplinary task force of providers and employees to identify the expectations and needs of individuals seeking jobs as an EMT or Paramedic.
2. Identify the cost of financing personnel and training and include those costs in reimbursement mechanisms.

Administration and System Planning/Evaluation

3. To secure adequate and stable funding for providers, local EMS agencies and the state EMS Authority
4. To provide appropriate legislation and reform necessary regulations to accommodate appropriate reimbursement
5. To implement a mechanism for periodic review of EMS funding needs and appropriate sources
6. To establish performance criteria in order to evaluate effectiveness of funding
7. To implement QI programs in order to provide continuing review of program effectiveness

Prevention and Education

8. Establish a multidisciplinary task force to include payers, reporting to the State EMS Commission whose charge it is to develop suggestions for studies and cooperative ventures between public health, public safety and payers directed at education which may reduce morbidity and mortality of certain patient populations and or disease and injury processes locally.
9. This task force shall actively seek out and broker the establishment of these cooperative ventures, measurement parameters (of intervention success, cost of delivery, and cost avoidance) and report its findings to the State EMS Commission. The State EMS Commission shall ensure wide distribution of the results of such ventures into the health care community with the goal of reporting successful and unsuccessful methodologies to reduce out of hospital morbidity and mortality and funding mechanisms.

10. The State EMS Authority shall draft suggested legislation to require all payers to contribute to a fund, administered by the Authority for the purpose of funding studies and educational ventures similar to those described above. The draft legislation shall be approved by the EMS Commission.

Dispatch and Communications

11. Implement pathway management programs in PSAP's, especially large regional centers, would be a cost effective way to reduce unnecessary costs and redirect patients from mandatory hospital transports (when transported) to more cost effective destinations.

First Responder and Medical Transportation

12. Develop a multidisciplinary task force of federal, state, local government EMS regulators, providers, and payors to:
    - Define First Response & Medical Transportation level of service provided within an EMS system.
    - Define the payors who finance the First Response & Medical Transportation Services component of EMS systems.
    - Define the payment criteria for the First Response & Medical Transportation Services component of EMS systems.
13. Lobby for legislative and regulatory reforms to assure equitable reimbursement by al payors based on costs of providing services.
14. Develop an advocacy effort to assist with legislative and regulatory reform efforts.

Medical Facilities

15. Develop a plan to provide information to the legislators and the new Governor on the problems with emergency department and hospital funding.
16. Support legislative efforts to require payers to pay allowable costs in a timely manner. Legislation should require payers to pay for medical evaluation.
17. Medical facilities should audit and document the costs associated with their support of the EMS system.
18. Develop an EMSA task force to review the statewide status of emergency departments and provide an annual report on the level of EMS system support and financial condition of emergency medical facilities.
19. Work with the hospital industry to determine the amount of uncompensated care provided through the ER and seek legislative funding for hospital services.
20. Expand the role of public health in the efforts to educate the public about effectively and appropriately using the ER.
21. Create appropriate task forces to work with community based clinics to expand their services to accommodate non-emergency patients.
22. Work with CNA state and community colleges to train more nurses to work with emergency departments and clinics.

Disaster and Medical Mutual Aid

23. Develop a multidisciplinary task force of federal, state and local governmental and EMS representatives to define, measure the problem and recommend funding source(s), process(es) and an action plan that would meet the stated needs.
24. If necessary, develop a legislative proposal that responds to the recommended action plan.
25. Develop an advocacy effort to assist with the legislative platform's execution.

Poison Control

26. Obtain stable funding through State General Fund increase.

Detail:

Personnel and Training

Goal:
To assure human resource availability to meet the obligation of EMS systems to provide essential, medically necessary services to the public.

Needs Statement:
As the pre-hospital healthcare industry continues to grow, EMS will need to promote and offer jobs that will attract and retain qualified individuals. In addition to financing the training of these individuals it will be essential to assure that the job of the EMT or Paramedic is rewarding from a personal perspective and is equitable in earnings and benefits to other jobs requiring similar skills and knowledge.

Background:
In private companies, financing for training as an EMT or Paramedic primarily falls to the individual seeking a position in EMS. Some funding is available for initial training through traditional mechanism's such as grants or scholarships. In the public sector, the financing for this training is generally borne by the employer. In both areas, continuing education is usually financed by the employer.

Example - Jane Smith has just graduated from high school and is interested in the medical field. Not financially able to attend College for 4 years without working, she enrolls in an EMT course offered through the local community college. After successfully completeing the course, she gets a job with an ambulance company. Continuing education for her EMT certification is paid for by the company and after some time, Jane is interested in becoming a Paramedic. Jane is a great employee so the company pays for her Paramedic training. After some time, Jane finds her

earnings do not meet her needs. She likes the medical field and continues her education ultimately earning a nursing degree and leaves the EMS industry.

Task Statements:

1. Develop a multidisciplinary task force of providers and employees to identify the expectations and needs of individuals seeking jobs as an EMT or Paramedic.

2. Identify the cost of financing personnel and training and include those costs in reimbursement mechanisms.

Current Payment Matrix Worksheet

Payment Factor		**Personnel Training Financing**
Who is Paid?		Educational entities offering training.
For What is Payment Made?		Training leading to certification as an EMT or Paramedic.
Who Pays?		Individuals, Providers, Federal and State educational entities, private grants, and taxpayers.
When is Payment Made?		At time of training.
Why is Payment Made/Needed? (Value)		Not stated.
How is Payment Made?		Cash Equivalent.
Unmet Payment Needs.		Not stated.
Other Inf. Comments		Not stated.

Future Payment Matrix Worksheet

Payment Factor		Personnel Training Financing
Who is Paid?		Educational entities offering training.
For What is Payment Made?		Training leading to certification as an EMT or Paramedic.
Who Pays?		Individuals, Providers, Federal and State educational entities, private grants, and taxpayers.
When is Payment Made?		At time of training.
Why is Payment Made/Needed? (Value)		Not stated.
How is Payment Made?		Cash Equivalent.
Unmet Payment Needs.		Not stated.
Other Inf. Comments		Not stated.

Administration and System Evaluation

Goal:
To procure sufficient and stable funding for high quality EMS system administration.

Findings:
The administration, planning and evaluation components of any EMS system are crucial to its success in serving its constituents effectively, efficiently and economically. Although these activities are universally agreed to be indispensable to a high quality system, funding can be inconsistent, inadequate, and unpredictable. Sound strategic funding options for these activities at all levels are essential to the future success of California's EMS system.

Background:
Administration, planning and evaluation tasks are undertaken by varied levels and participants in emergency care. These include individual provider agencies and collaborative groups, medical control entities, local EMS agencies, and the California EMS Authority. In many cases, Emergency Medical Care Committees participate in the processes.

The participation of each group is essential, and their integration offers the promise of the best system possible. In spite of the importance of EMS as a whole, and these components in

particular, funding remains a source of considerable uncertainty, particularly for single-county LEMSAs and other public entities.

The state EMS Authority is funded by the state general fund, federal grants, state special funds, and administrative fees. Many of these sources provide inconsistent revenues.

Funding mechanisms for local EMS agencies vary widely. They are typically funded by a combination of county general fund revenues, benefit assessments and special local taxes, SB 12/612 revenues, federal grants, realignment funds, provider fines, fees for accreditation of facilities, authorization of providers and certification of personnel, or special project grants. They are sometimes funded in large part by local general funds. Since this model emerged in the early 1970s, these revenues have been sharply reduced, while the expectations of a more informed public have risen. Efforts to sustain funding levels with special fees and taxes approved by voters meet with only limited success.

Multi-county agencies obtain funding from the state general fund, which is matched by local hard/soft matches. An augmentation was recently approved which will provide additional funding for unmet needs. In the current political climate, few, if any consider this funding source stable. Budget approval and disbursement processes are often lengthy and unpredictable. In times of critical cash flow this poses a significant hardship.

In times of reduce state revenues it is of continuing concern that state general fund revenues will not be available to LEMSAs.

Grant funds allocated for special projects (federal CDC Healthcare Preventative Block Grants/ Prevention 2000) are relied on by many agencies to develop their systems. Competition for these funds continues to increase, and their continued availability is far from assured. There have always been more requests for funding than there have been available funds.

Provider agencies are predominantly funded by fees for service. Those faced with reduced funding will often sacrifice administration, planning and evaluation activities and other services considered relatively non-essential in order to maintain field operational capabilities. This offers only a very short-term solution, for without sound administration, planning and evaluation, no EMS system will continue to serve its communities or participants adequately.

A particular crisis exists in the First Responder arena. While ambulance services are routinely reimbursed by private and public third party payors, first responder agencies are ineligible to receive payment from both Medicare and Medi-Cal. Lack of meaningful funding for this important component continues to diminish system stability.

Example - For FY 98-99, a state budget was approved on August 21, nearly two months after the prior year's funding had been exhausted. It is widely known that California's budget is routinely delayed, often for a protracted period, and with far-ranging effects.
The EMS Authority suffered impediments to many of its functions and activities as a direct result. In some cases activities were curtailed and projects delayed. Increased costs were

incurred because it became necessary to use outside sources of products and services willing to wait indefinitely for payment.

It is unknown when the current year's disbursements will be received by LEMSAs. Activities and expenditures by LEMSAs are often curtailed during this period of each year. Those LEMSAs which support the administrative, planning and evaluation activities of providers are faced with the choices of suspending support activities, drawing on reserves to fund them, or going into debt. This applies not only to multi-county agencies, but those other LEMSAs whose funding is contingent upon disbursements to their counties from the state.

The evolution in payment to provider agencies continues to force many to implement efficiencies, often at the expense of those areas addressed by this group. Many services which do not generate revenues or support those activities directly are considered secondary, or even expendable.

EMCCs and other groups which participate in administration, planning and evaluation of their EMS systems often rely on some type of support which ultimately receives some type of funding from the LEMSA. Forced austerities by these agencies, even seasonal, result in delayed and cancelled meetings and other activities.

During the final months of each fiscal year and the early months of the next, state and local agencies, and those which rely on them for funding and support, find that they don't know either when their funding for the year will begin to filter in or what level of funding they might receive.

This is only one example of the fiscal uncertainty faced by the EMS community and the effects it can have.

Task Statement:

3. To secure adequate and stable funding for providers, local EMS agencies and the state EMS Authority
4. To provide appropriate legislation and reform necessary regulations to accommodate appropriate reimbursement
5. To implement a mechanism for periodic review of EMS funding needs and appropriate sources
6. To establish performance criteria in order to evaluate effectiveness of funding
7. To implement QI programs in order to provide continuing review of program effectiveness

Implementation Recommendations:

To evaluate establishment of EMS regions throughout California. These may be single or multi-county areas, and should be established based upon EMS system development.
Funding mechanisms should be similar in each regional agency, and based on identified needs and priorities.
A task force of the EMS Commission should be established in order to provide follow up and follow through on these issues and recommendations.

Payment Factor	Component/Function **Administration/Planning/Evaluation**
Who is paid?	LEMSA EMSA Providers' Management (Ambulance, First Response) System Volunteers (e.g., physicians, nurses, paramedics, consumers)
For what is payment made?	Medical control, system planning (e.g., trauma system plan), regulatory role, consumer protection, increased efficiency/cost savings, system evaluation, data analysis, consumer information, advice to elected officials, LEMSAs are the common conduit holding the local EMS system together and spend much time and energy communicating with the EMS system components and facilitating communication between them (e.g., providers, hospitals, dispatch centers, paramedics, fire service, training programs, other EMS agencies -e.g., EMSA),
Who pays?	LEMSA: Varies greatly between systems but some sources include county general fund, state through general fund (for regional LEMSAs only), benefit assessment taxes, traffic ticket payers (SB12 Fund), federal grants, realignment $, provider fines, fees (e.g., trauma center fees, certification/accrediation, ambulance permits), special project grants (public and private) EMSA: State general fund, Federal grants, State special fund (EMSC?), paramedic license fees, ??? Providers' Management: Health insurers through patient fees or other compensation arrangement, taxpayers through local taxes, capitation and other non-fee MCO methodologies, other sources such as victims of violent crime funds.
When is payment made?	For fees - when services are rendered. For government funding sources - on going sometimes based on invoicing, project completion, etc. For some MCO compensation for Providers payment precedes the services.
Why is payment made/needed? (Value)	Provide for clinical quality, efficiencies, consumer protection, system planning and evaluation, (e.g., design of trauma system plan and then determine if it makes any difference), consumer protection, consumer information. Permit a system made up of multiple components (public agencies, health care organizations, and private businesses) to function as a seamless system of emergency medical care. Responsiveness to rapidly changing needs, technologies, and capabilities in EMS. Conduct evaluation activities (macro and micro) of the EMS system that include evaluating fiscal effectiveness.

How is payment made?	Government budget process, payments by grantors to grantees after invoicing, payments from state for regional EMS agencies after invoicing meeting other requirements, payment by persons or entities for specific services rendered.
Unmet Payment needs Other Info Comments	There is GREAT variation between funding sources (and funding levels) between LEMSAs which is largely related to a very limited revenue stream for governmental EMS administration. Continued funding by this method isn't realistic or viable. Note: Medi-Cal reimbursement to EMS providers is unrealistic and insufficient. HCFA reimbursement is not equitable for services provided (e.g., transport only).
Discussion	Current funding for LEMSAs is not viable. Funding sources are very different today than when LEMSAs started in the 1970s. In the early years large and mid-sized counties had sufficient funding for LEMSAs from sources such as county general funds. Smaller counties did not have the financial resources to establish LEMSAs. The state provided partial funding to LEMSAs counties that formed EMS regions comprised of at least three counties for the purpose subsidizing rural areas with insufficient financial resources and to encourage EMS regionalization. In 1998 things are different. Many of the financial resources that were available to counties in 1975 no longer exist. Many LEMSA budgets rely on unstable funding sources. State funding for LEMSAs is limited to regional agencies. While there is a financial incentive to form EMS regions there does not appear to be many others. We should strive to develop EMS regions for best function rather than on number of counties. For instance, it seems reasonable that Los Angeles County should qualify as a region on its own. Other regions should be formed with consideration for factors such as the flow of patients to specialty centers, transportation patterns, etc. For instance it would make sense to form a Bay Area region. We believe that it is time for a statewide EMS system, made up of regions that are linked to each other, to the state, and to counties. We should then pursue funding of the appropriately designed regions using a funding formula that is equitable. We believe that regionalizing LEMSAs would produce substantial cost savings as the result of economies of scale and eliminating duplication of activities (e.g., do we really need 32 different sets of paramedic treatment protocols?). This is not

	imply that all regions be exactly the same. One size fits all is not our vision. However, we believe that if we design regions that make sense by function, standardization of many components within a region is quite possible and desired. It is also probable that regionalizing EMS in California would be of benefit related to many other areas e.g., disaster planning, medical mutual aid, communications, training, to name a few.

Prevention and Education

Goal:

Develop and maintain an adequate funding process for Out-of-Hospital Injury and Illness Prevention and Education Programs.

Needs Statements:

Reimbursement for Out-of-Hospital Injury and Illness Prevention and Education Programs should be tied to the value (as opposed to cost of production) of those services.

Reimbursement for Out-of-Hospital Injury and Illness Prevention and Education Programs should be available to those agencies conducting such services.

Background:

Refer to Current Payment Worksheet attached.

An assumption is made that the health care cost avoidance realized by third party payers because of current out of hospital programs could be increased through an enhanced and more structured and organized delivery system.

That assumption should be tested through cooperative ventures between public safety (private and public), public health, and payers.

Payers should be required to contribute to the public health and safety through partial or complete support of proven successful programs. Contribution may be in part or in whole offsetting program costs.

Task Statements:

8. Establish a multidisciplinary task force to include payers, reporting to the State EMS Commission whose charge it is to develop suggestions for studies and cooperative ventures between public health, public safety and payers directed at education which may reduce morbidity and mortality of certain patient populations and or disease and injury processes locally.

9. This task force shall actively seek out and broker the establishment of these cooperative ventures, measurement parameters (of intervention success, cost of delivery, and cost avoidance) and report its findings to the State EMS Commission. The State EMS Commission shall ensure wide distribution of the results of such ventures into the health care community with the goal of reporting successful and unsuccessful methodologies to reduce out of hospital morbidity and mortality and funding mechanisms.
10. The State EMS Authority shall draft suggested legislation to require all payers to contribute to a fund, administered by the Authority for the purpose of funding studies and educational ventures similar to those described above. The draft legislation shall be approved by the EMS Commission.

Task Implementation Recommendations:

General recommendations are directed at a two front approach, one is the task force seeking cooperative ventures and funding. The second is a legislative approach requiring payers to fund meritorious ventures.

Current Payment Matrix Worksheet

Payment Factor		**Prevention and Education**
Who is Paid?		LEMSA's, Hospitals, Private Practices, Home Health Care Entities (Private and Fire take costs out of non-targeted operating revenues)
For What is Payment Made?		A variety of public safety (fire safety, drowning, fall, dial 911, burn prevention etc), home self help (CPR classes, diabetic self care etc), and health prevention (weight loss, cardiac risk etc)
Who Pays?		Grants (Federal), Third Party Payers, Private Donations, Foundations
When is Payment Made?		Prospectively (Grants and Capitated), Retrospectively based on Volume or Service
Why is Payment Made/Needed? (Value)		Prevention/Education programs in the health care **AND** public safety sectors may result in: 1) injury/illness avoidance, 2) lower mortality and morbidity, 3) drive health care services to lower less expensive work forces and self care. All these drive down the overall cost of health care services through reduced consumption of health care resources.
How is Payment Made?		Dollar payment for the development/provision of a service or product. Provision of "in-kind" services; for example - donation of media access.
Unmet Payment Needs.		Most public and private sector public safety or health care programs are not compensated in any way.
Other Inf. Comments		Public expectation of these programs is growing to be the norm. Public and Private entities are increasingly viewing some educational outreach programs as valuable marketing tools.

Future Payment Matrix Worksheet

Payment Factor		Prevention and Education
Who is Paid?		LEMSA's, Hospitals, Private Practices, Home Health Care Entities (Private and Fire take costs out of non-targeted operating revenues)
For What is Payment Made?		A variety of public safety (fire safety, drowning, fall, dial 911, burn prevention etc), home self help (CPR classes, diabetic self care etc), and health prevention (weight loss, cardiac risk etc)
Who Pays?		Grants (Federal), Third Party Payers
When is Payment Made?		Prospectively (Grants and Capitated), Retrospectively based on Volume or Service
Why is Payment Made/Needed? (Value)		Prevention/Education programs in the health care **AND** public safety sectors result in: 1) injury/illness avoidance, 2) lower mortality and morbidity, 3) drive health care services to lower less expensive work forces and self care. All these drive down the overall cost of health care services through reduced consumption of health care resources. The "Value" is proven/assumed through cooperative studies/experiments.
How is Payment Made?		Payment is for the development/provision of a service or product. Payment made based on the value of the service to the "At Risk" entities. (Based on the assumption that the "program" has value and results in some cost avoidance to the Payer and positive health affect on the patients.)
Unmet Payment Needs.		Value based reimbursement would reasonably reduce but not completely eliminate any unmet payment needs. See Inf./Comments below.
Other Inf. Comments		Public expectation of these programs is the norm. Public and Private entities view some educational outreach programs as valuable marketing tools and may subsidize/cost match with Payers based on that value.

Dispatch and Communications

Current Payment Matrix Worksheet

Payment Factor		
Who is Paid?		Public Safety Answering Points (PSAP) receive funding from the State 911 fund for upgrading or installing 911 equipment. This funding is in the form of a grant and each PSAP is eligible to apply every five (5) years. Some Private Call Answering Points (PCAP) receive funding in the form of contracts for dispatch or pathway management services.
For What is Payment Made?		PSAP: For 911/call handling equipment PCAP: For dispatch or pathway management services
Who Pays?		PSAP: State 911 fund PCAP: Private insurance companies/Managed Care Organizations (MCO)
When is Payment Made?		PSAP: Every five years, based on application for the 911 grant money. PCAP: Yearly, based on contract negotiations.
Why is Payment Made/Needed? (Value)		PSAP: 911 money is needed to keep up with the changing technology. PCAP and PSAP: Pathway management funds assist in reducing non-medically necessary transports and costs. PSAP's could also benefit from these funds and could then implement Pathway Management programs as an integral part of the initial screening before the 911 dispatch.
How is Payment Made?		PSAP: Cash and project assistance PCAP: Cash and capitated contracts
Unmet Payment Needs.		BOTH: Currently, few of the MCO's provide funding for pathway management at the PSAP and PCAP level. Implementation of the pathway management programs in PSAP's, especially large regional centers, would be a cost effective way to reduce unnecessary costs and redirect patients from mandatory hospital transports (when transported) to more cost effective destinations.
Other Inf. Comments		

First Responder and Medical Transportation

Goal:
To assure equitable reimbursement by all payors for appropriate First Response and Medical Transportation Services provided within an EMS system.

Findings:
Currently Medical Transportation Services are reimbursed at different rates depending on the payer. However there are very limited mechanisms for reimbursement for Public Agency First Response Services other than the traditional tax based subsidy. This creates an unstable funding source for the First Response & Medical Transportation Services Component of an EMS system that can place the system in jeopardy of meeting its obligations to provide essential services to the public. All constituent groups within EMS must work toward creating equitable reimbursement by all payors to assure stable EMS systems.

Background:
Traditionally reimbursement for medical transportation services within and EMS system has been established by free market pricing (customary charges) by the provider or through rate setting by a local governmental entity. Reimbursement is primarily based on fee for service pricing. Cost shifting for uncompensated and indigent care has led to unstable and inequitable financing for First Response and Medical Transportation services. Reimbursement is made for different levels of Medical Transportation Services including critical care, advanced life support ambulance, basic life support ambulance, gurney/stretcher van and wheelchair. Minimum criteria have been established by payors before reimbursement will be made for the service including: reasonableness, medical necessity, and the transport of the patient from the origin of the call to an approved medical facility. A majority of the payors only recognize Medically Necessary Transportation Services for reimbursement, and exclude reimbursement for all other types of Prehospital Care.

Task Statements:
11. Develop a multidisciplinary task force of federal, state, local government EMS regulators, providers, and payors to:
    - Define First Response & Medical Transportation level of service provided within an EMS system.
    - Define the payors who finance the First Response & Medical Transportation Services component of EMS systems.
    - Define the payment criteria for the First Response & Medical Transportation Services component of EMS systems.
15. Lobby for legislative and regulatory reforms to assure equitable reimbursement by al payors based on costs of providing services.
16. Develop an advocacy effort to assist with legislative and regulatory reform efforts.

Implementation recommendations:

Shaping the Future of EMS in California

Given the scope of and complexity of the issue to be addressed, implementation of assuring equitable and stable reimbursement for the First Response & Medical Transportation Services component of EMS systems will take several years at a minimum and substantial resources.

Current Payment Matrix Worksheet

Payment Factor		**First Response and Medical Transportation Services**
Who is Paid?		Ambulance providers (air and ground). Gurney/stretcher van providers who bill for their services. Traditionally rescue services are not reimbursed.
For What is Payment Made?		Payment is not needed from non-traditional sources. Inequities in payments from traditional sources needs to be addressed.
Who Pays?		Medial Transportation is reimbursed through Federal and State insurance programs (Medicare and Medicaid); private pay; and taxpayers. The public agency First Response Funding usually comes from Local and State property taxes, and general fund revenue, or through contractual agreements with the private medical transportation provider.
When is Payment Made?		Upon receipt of bill or payment of taxes.
Why is Payment Made/Needed? (Value)		Payment is not needed from non-traditional sources. Inequities in payments from traditional sources needs to be addressed.
How is Payment Made?		Cash equivalent.
Unmet Payment Needs.		Cost shifting for uncompensated and indigent care must be addressed.
Other Inf. Comments		

Shaping the Future of EMS in California

Future Payment Matrix Worksheet

Payment Factor		First Response and Medical Transportation Services
Who is Paid?		Providers who respond and/or transport a patient for medcially necessary reasons.
For What is Payment Made?		First response & medical transportation services provided under one of two established models: (1) A *response readiness* model defined as a static standard of coverage, or (2) a *utilization* model defined as fees paid for services provided within established contractual standards.
Who Pays?		The medical transportation component should be reimbursed through federal and state insurance programs, private insurance, private pa, and tax-payers. EMS generated revenue for first response and rescue services should be handled through a detailed reimbursement model utilizing a single county wide distribution point and should be included as part of a local EMS system plan. Payments received at the established distribution point may originate from several sources; e.g. transport fees, third party payor, managed care, special tax assessment, and local governmental taxes and general fund dollars.
When is Payment Made?		Medical transportation should be handled as traditionally done today, with presenting a claim to federal and state insurance programs; private insurance through capitated or fee for service agreements; private pay; and tax payers. Payment for first response or rescue should be made in one of two methods based on the contractual model: (1) *response readiness* models should be paid in a capitated manner based on an established fiscal or calendar cycle, or (2) *a service utilization* model should be based on a fee for services rendered within a specified fiscal or calendar billing cycle.
Why is Payment Made/Needed? (Value)		Payment is not needed from non-traditional resources. Inequities in payments from traditional sources needs to be addressed.
How is Payment Made?		Cash equivalent.
Unmet Payment Needs.		Uncompensated, indigent care.
Other Inf. Comments		

Medical Facilities

Goal:

To support the necessary funding of emergency medical facilities in order that stability exists to assure optimal care of sick and injured patients.

Needs Statement:

California hospitals and medical facilities need secure, complete and timely reimbursement for incurred costs of providing emergency medical services. Emergency medicine is the point of entry into the health care system and as such directly impacts the prehospital EMS system. Hospital closures and/or diversions negatively effect the ability of prehospital providers to provide quality care. There is a need to enhance the **timeliness** of payment by insurance providers. Payers should be required to reimburse hospitals for medical screening and triage. A system of insurance coverage needs to be developed to support the "true" indigent patient with no source or ability to pay.

The California EMS system needs to develop policy that provides for delivery of stable patients to their insured facility. Fully 50% of all emergency department visits are non-emergent. All patients do not need to go to the closest hospital.

Background:

Hospital emergency departments continue to be the point of entry into the health care system for acutely sick and injured patients. The emergency departments play a significant role in the medical evaluation of patients that are delivered by the EMS system. Since the beginning of EMS the hospital's role has directly been linked to prehospital care not only because of the delivery of patients but also through medical oversight and provider education. Emergency departments provide directions (orders) to prehospital providers and are actively involved in continuous education and quality improvement. Physicians and nursing representatives of base hospitals serve on various EMS Agency prehospital committees providing medical advice on prehospital policies and procedures. Hospitals throughout California have supported EMS by directly contributing:

- resources/supplies
- training
- medical oversight
- assistance in research
- medical consultation
- administrative support
- air ambulance services
- patient billing information
- Hospital Emergency Response Teams

- disaster assistance

Example:

California hospitals and emergency medical staff provide uncompensated support for the EMS system. Specifically, hospitals and staff provide medical direction and oversight of prehospital care. The base hospital assists with EMS quality improvement. Costs associated with these services have not been reimbursed. Unfortunately, the cost and staff time associated with this support has not been well documented.

In addition to the above non-reimbursed costs, payment for emergency department billable service is often delayed by the responsible payor. Payers refuse to cover costs associated with the medical evaluation of emergency department patients. The evaluation examinations are often used by payers to determine the appropriateness of the emergency department visit. A lack of secure funding has resulted in downgrading of emergency departments and in some cases, emergency department closures.

Task and Implementation Recommendations:

16. Develop a plan to provide information to the legislators and the new Governor on the problems with emergency department and hospital funding.

17. Support legislative efforts to require payers to pay allowable costs in a timely manner. Legislation should require payers to pay for medical evaluation.

18. Medical facilities should audit and document the costs associated with their support of the EMS system.

19. Develop an EMSA task force to review the statewide status of emergency departments and provide an annual report on the level of EMS system support and financial condition of emergency medical facilities.

20. Work with the hospital industry to determine the amount of uncompensated care provided through the ER and seek legislative funding for hospital services.

21. Expand the role of public health in the efforts to educate the public about effectively and appropriately using the ER.

22. Create appropriate task forces to work with community based clinics to expand their services to accommodate non-emergency patients.

23. Work with CNA state and community colleges to train more nurses to work with emergency departments and clinics.

Current Payment Matrix Worksheet

Payment Factor		Medical Facilities
Who is Paid?		In the hospital, the emergency department physician as well as the on call specialty physician is paid. In addition, the hospital is reimbursed for services, as is the staff in the hospital who supports the emergency department.
For What is Payment Made?		Medical Facilities are paid for costs. Medical services, including the screening and triage functions provided by the hospital. Please note all payments made to the hospital for services are paid on a discounted rate.
Who Pays?		Depending on the type of patient utilizing the emergency department. Payments come from a variety of sources. Primary payment sources today are Medicare, Medi-Cal, California Healthy Families Program, health maintenance organizations, auto insurance, other insurance, tobacco tax, SB12/612 and other state and local sources. Very few patients are covered under indemnity plans, and there still are a significant number of patients who are classified as charity cases. (No payor source).
When is Payment Made?		Patient billings are made after services are rendered. However, most payments are received from 4 to 6 weeks after billing. In some cases protracted discussions about the appropriateness of care results in greater delays of payment or in some cases, partial or no payment. Late payments are made by some federal agencies.
Why is Payment Made/Needed? (Value)		Payment is needed to reimburse the hospital for their costs to provide the service and to provide for a return on investment.
How is Payment Made?		All payments are made through checks/warrants issued by billed services. In the case of managed care contracts, payments are made on some pre-determined schedule based on a fixed rate. The pre-determined schedule could include capitated, per diem, or other payment methods.
Unmet Payment Needs.		Some unmet payments result in cost shifting. Hospitals often "write-off" unmet payments by the various sources. In some cases, hospitals have attempted to adopt co-payment methods from patients for services that are not fully covered by the insurance company. It is important to note the difference between being reimbursed for "cost" versus charges.
Other Inf. Comments		Hospitals by law must see all patients that present at the emergency department. At a minimum each patient receives a medical assessment and is appropriately triaged according to the severity iof

		their condition. Medical assessment does not require an assessment by a physician and is often times provided by a nurse practitioner or a physicians assistant. Fully 50% of all hospital emergency department visits are non-emergent. Very often hospitals are not paid for these types of cases. Participating in a regional EMS system is a voluntary act by hospitals. Base Hospital responsibilities and the education of prehospital personnel is paid for by the hospital. Every attempt should be made to ensure hospitals are appropriately reimbursed in order to maintain their emergency department. The emergency department is a vital element of the entire emergency care system. Several approaches need to be taken to ensure that hospitals remain financially able to support the EMS system. These approaches include but are not limited to: • Spreading reimbursement over multiple resources instead of concentrating on one source. Coordination of payment resources is essential. • Requiring that insurance sources pay for a portion of medical facilities infrastructure. • Set a minimum standard emergency department benefit for all insured patients. This should cover the hospital cost of medical assessment. • Develop EMS hospital policies that support the direct transport of patients to the appropriate medical facility. Consideration should be given to the HMO status of the non-critical stable patients.

Disaster and Medical Mutual Aid

Goal:

Develop and maintain an appropriate and sustainable funding process for EMS assistance during moderate and major emergency events.

Needs Statement:

There is a need to develop consistent and sustainable payment processes for all EMS providers. A single source of payment from a federal organization is needed to assure that providers supply appropriate resources and that coordinating agencies provide appropriate coordination services irrespective of funding source(s).

Funding mechanisms to ensure meaningful preparedness by ambulance services and hospitals should be explored.

Practical, sustained payment mechanisms for multi-casualty incident preparedness and response should be explored.

Background:

Traditional disaster reimbursement eligibility (e.g. OES/FEMA) does not cover all costs nor do they cover all entities (private firms). Relying on a fee-for service (FFS) payment system is problematic during major emergencies, as the documentation necessary to bill FFS is often secondary or impossible to collect. Some EMS providers do not have a FFS option. Also, cost factors used to justify traditional FFS events do not represent the unique cost impact during major emergencies

Example:

During the Loma Prieta Earthquake, some prehospital providers did not receive payment for services rendered as they did not have the required documentation of costs or such documentation did not meet the requirements of the paying agency (e.g. FEMA). Other private entities were not paid, as they were not eligible even though they supplied similar services. Some hospital providers did not get paid or payment was delayed because of their lack of familiarity with the requirements and the lack of understanding what sources of payment were available. The unique and unpredictable circumstances of a major emergencies defy complete logistical and resource planning for all providers.

Task Statements:

26. Develop a multidisciplinary task force of federal, state and local governmental and EMS representatives to define, measure the problem and recommend funding source(s), process(es) and an action plan that would meet the stated needs.
27. If necessary, develop a legislative proposal that responds to the recommended action plan.
28. Develop an advocacy effort to assist with the legislative platform's execution.

Implementation Recommendations:

The scope and complexity of the study phase and the anticipated action plan are expected to be substantial and as such the implementation of the action plan could take well over five years.

Considerable change could be required for existing programs to meet the needs identified here. The unique composition, resources and limitations of the EMS system should be a factor throughout review and modification processes.

Current Payment Matrix Worksheet

Payment Factor		**Component/Function:** **Disaster and Mutual Aid**
Who is paid?		1. Local and state government agencies and private-non-profit agencies with documented eligible costs. (Office of Emergency Services (OES) Natural Disaster Assistance Act and Federal Emergency Management Agency (FEMA) Stafford Act) 2. EMS, hospitals, and other healthcare providers on a fee-for-service or insurance reimbursement basis. 3. Healthcare providers with a designated response role in the local government disaster plan and tasked by the responsible agency to perform that service. (Response costs billed to the tasking agency) Funding for this component is uncertain. • NOTE: Mutual aid is, by definition, uncompensated. Those with mutual aid agreements are increasingly being denied reimbursement by FEMA for that reason.
For what is payment made?		1. Eligible costs as defined by the administering agency (OES and/or FEMA) 2. Costs billable to patients or eligible for insurance reimbursement 3. Extraordinary response costs as agreed upon with the tasking agency. Extraordinary costs mean those costs that are not reimbursable through patient billing, insurance, or other means.

Who pays?		1. OES and/or FEMA 2. Patient receiving the service or applicable insurance. *3.* Tasking agency at the local or state level.
When is payment made?		Indeterminate, dependent on who is billed, what costs are approved, and the skill and available time of those doing the documentation for submittal to FEMA Can be 30 – 60 days (fee-for-service (FFS)) or years (FEMA). Claims under $47,100 are paid more quickly and with less effort required by requesting agencies.
Why is payment made/needed (value)?		To support unique and unusual logistical and cost impact of major emergencies on EMS and other health care providers and to provide a funding stream for those additional services needed that might not otherwise be required during routine emergencies (e.g. food and housing for EMS personnel). Unfortunately, reliance on an FFS payment system is problematic during major emergencies, as the documentation necessary to bill FFS is often secondary or impossible to collect. Most importantly, reimbursement is necessary to ensure prompt, willing allocation of necessary resources by response organizations.
How is payment made?		Through checks/warrants issued to eligible entities or by checks or electronic media for FFS providers.
Unmet payment needs.		Traditional disaster payment sources (e.g. FEMA) do not cover all costs (housing, feeding, and other support for response personnel, for example) nor do they cover all entities (private firms). Some of these items can be billed to the state or local tasking agency, however ultimate payment is uncertain and often untimely. Fee for Service billing is problematic during major emergencies, as the documentation necessary to bill FFS is often secondary or impossible to collect. Sources, mechanisms, requirements and limitations for funding/reimbursement are not widely understood in the EMS community. A sound understanding of these issues is essential. Mutual aid (MA) agreements are generally entered into with the idea of a large local event in mind. Disaster response can involve extraordinary commitments and expense beyond those envisioned during agreement development. Continued denial of reimbursement for MA responders could jeopardize future agreements to the detriment of many responses . It is unclear whether local governmental agencies or traditional funding agencies such as the Health Care Financing Administration (HCFA) are willing to pay for ambulance evacuation of bedridden

		patients from threatened or damaged facilities, with or without an official evacuation order. Cost factors used to justify traditional FFS events do not represent the unique cost impact during major emergencies. Hospital overcrowding and diversion occur, even in day-to-day operations. Facilities feel that mechanisms to gear up rapidly for large influxes of patients are not affordable. Multi-casualty incidents are susceptible to ambulance shortages because it's considered too costly to maintain surpluses of response-ready units.
Other info/comments		The financial needs of providers that have converted to prospective payment systems (e.g. capitation) that have traditionally relied on FFS systems for payment will not be adequately compensated with the new PPS system unless they build disaster costs into their assumptions or alternative sources are found.

Poison Control

Current Payment Matrix

Payment Factor		Component / Function: POISON CONTROL SERVICES
Who is Paid?		Poison Control Services Contract Provider (currently University of California)
For What is payment made?		1. Public and provider access to poison advice and information via a single statewide toll-free telephone number and other media. 2. Public education and poison prevention activities. 3. Development of clinical and telephone triage protocols for managing poisonings. 4. Data collection. 5. Hazardous materials incident response advice.
Who pays?		State General Fund pays $1 M/year ($1.75 M for 98/99 SFY) California Medical Assistance Commission (CMAC) may match some of this for 98/99 SFY - Future match is tenuous. Host hospitals have been paying the rest of the costs
When is payment made?		Varies
Why is payment made/needed? (Value)		Advice provided regarding poison exposures to parents, seniors, other individuals, and medical professionals, results in appropriate treatment of poison exposures and drug interactions, thus reducing death and disability. Frequently, advice allows safe treatment at home, thus avoiding unnecessary, costly visits to ER. Advice provided to public safety responders to Haz Mat incidents protects responders and public.
How is payment made?		State General Fund money is transferred from EMSA budget to CMAC to PCS contractor.
Unmet Payment Needs		Consolidated PCC system costs $5.5 - $6 M/ year to operate. The SGF has been providing $1 M/ year ($1.75 M for SFY 98/99). Because some of the callers receiving advice to treat safely at home are Medi-Cal patients who might have made a costly, unnecessary ER visit at the expense of the tax-payers, the CMAC has been providing some matching funds for the SGF dollars. CMAC has indicated a reluctance to continue this practice. The four hospitals that house the PCC operations have been picking up the rest of the costs out of their own budgets, but say they cannot continue to do so.
Other Info/ Comments		The current administration has sought, without success, funding for PCS from insurance companies and HMOs, which benefit financially from advice given to members to treat at home, thus avoiding costly ER visits.

Future Funding -
Poison Control Services

GOAL:

Provide permanent, stable, funding for the ongoing operation of California's poison control system (PCS).

NEEDS STATEMENT:

California's poison control system needs stable funding. This program helps protect the health and safety of the citizens of California, but it has not had stable funding for several years. Except for a $750k SGF augmentation effective in the current 98/99 SFY, funding sources for the poison center program have diminished over the last seven years. Currently, a total of $1.75 million of the State General Fund is being used to augment the CPCS budget. This pays for only 30% of the total PCS budget, which ranges from $5.5 to $6 million annually. The unpredictable funding has caused staffing shortages and cuts in health education activities, and the system is in danger of closing.

BACKGROUND:

California's poison center program was established in 1987 as part of the Governor's Children's Initiative. The program is mandated by State Law, Chapter 972, Statutes of 1987 (AB 580). This law requires the EMSA to establish minimum standards for the operation of poison control centers. It also authorizes the Authority to establish the criteria for designation of poison centers.

In 1987 there were seven regional poison centers, and the State's contribution to the system was $1.7 million. That amount was reduced to $1 million in 1991. The centers were unable to generate stable and reliable funding sources to finance their operations, resulting in funding crises each year since then. In March 1995, Blue Cross of California, through the National Health Foundation, provided $5 million over two years to help operate the poison control system and fund a study to determine how to make the program more efficient. The report was released in February 1996, and recommended that a Request for Proposals (RFP) be issued by the EMSA to seek the development of a single consolidated system that would result in overall cost savings by utilizing the economics of scale, minimizing duplication, and maximizing resource use. A proposal from the University of California, representing a consortium of four UC affiliated poison centers, was judged most likely to accomplish the goals. This new system began operations in January of 1997. Under this system, the four UC-affiliated hospitals (San Francisco, UC Davis, UC San Diego and Fresno Valley Children's Hospital), work together as a single administrative entity.

Legislation, AB 3103 was introduced in 1992 that would have provided funding for up to two thirds of the operating expenses of California's regional poison control centers. This was to be accomplished by requiring manufacturers of poisonous products to pay an annual fee. The fee would have been based on the manufacturer's market share of products involved in poisonings reported to California's poison centers. The bill was vetoed by the Governor in part because it would have imposed additional taxes on the business community. In his veto message, the governor directed the Authority to undertake the appropriate consolidation of poison control centers to reduce administrative costs and to specifically seek financial support from those organizations that directly benefit from the service. Since that time, the consolidation has taken place. Extensive efforts have been undertaken to seek voluntary contributions from those organizations that benefit from the service, including health insurers, HMOs, etc. Chemical manufacturers and pharmaceutical companies have also been approached. Hospitals and health care providers have been asked to contribute to pay for medical consultation contract services. There has been no significant response to these efforts.

EXAMPLE:

The CPCS provides free public exposure advice to all citizens of California. There were over 323,000 calls to the CPCS in 1997. Of these calls, 250,000 were for suspected or actual human exposures. The poison control centers are heavily utilized and have become important first responders for poison emergencies, thereby saving lives, preventing disabilities, and serving to prevent unnecessary health care costs. They are relied upon by the public and health care professionals for information regarding life-threatening emergencies.

The poison control system provides the following benefits:

- Ensures that all persons needing advice for exposures or suspected exposures have access to that information 24 hours a day via a toll-free number;
- Prevents unnecessary visits to the emergency room, as well as the overuse of emergency response teams;
- Provides cost savings to Medi-Cal by keeping Medi-Cal patients out of emergency rooms;
- Decreases the burden on 9-1-1 operators;
- Improves care of poisoned patients in the hospital by providing continuing education for healthcare professionals in areas of poisoning management and medical toxicology;
- Reduces treatment time to avoid symptoms, reduce illness and injury and prevent death from poisoning;
- Provides emergency physicians with current information on toxicity as well as direct assistance regarding treatment methods for severe exposure cases; and
- Saves health care dollars by treatment at home without trips to emergency rooms and by providing education to prevent poisonings before they occur. It is estimated that for every $1 spent on poison control services, $7 is saved. This represents a health care savings of over $42 million in California.
- Provides information to public safety personnel in response to hazardous materials spills.

TASK STATEMENTS:

(1) Ensure that all efficiencies that can be implemented have been implemented.
(2) Consolidate further if it will increase efficiencies.
(3) Develop a plan to educate legislators and the new governor of the need to adequately support the poison control system.
(4) Seek and support a State General Fund budget augmentation for the poison control system.
(5) Develop a multi-disciplinary EMS task force to pursue either voluntary or mandatory contributions from beneficiaries (including HMOs and health insurers) of poison control services.

IMPLEMENTATION RECOMMENDATIONS:

Obtain an increase in State General Fund support for the California Poison Control System to a total of $5.5 million annually. This would provide a stable ongoing source of revenue for the program. Many Legislators have indicated that they would support such a budget item. During deliberations of EMSA's budget, members of both legislative committees indicated that a permanent solution to the poison center funding crisis was simply to fund the CPCS out of the General Fund. Poison control centers provide a public service and should be funded by the State. Providing State General Fund support would ensure that these services will continue and that there will be no negative impact on the public's health and safety.

Alternatives; Considered, But Not Viable:

1. Initiate or support an additional tax or surcharge on telephone bills or other appropriate source to raise funds for poison control services totaling at least $5.5 to $6 million annually. Although poison control services are seen by many as a public service that should be funded through a state revenue source, such new or increased taxes or surcharges would be a difficult initiative to move forward. The opposition would be great.

2. Implement aggressive voluntary private fund raising program to raise funding from health insurers, HMOs, hospitals, pharmaceutical companies and other beneficiaries to the program. A variation to this option includes a legislative requirement for financial support by such organizations. Voluntary contributions by health insurers, HMOs, and other health organizations would be difficult to obtain, unpredictable, and not equally distributed on the basis of actual benefit.. Legislatively mandated payments would be actively opposed by health insurers, HMOs, and other target organizations.

3. Pursue either full federal funding or partial funding to augment other funding sources. The Authority has been contacted by the Governor's Washington, D.C. Office regarding the funding for Poison Control Centers in California. They were interested in how much money the Federal Government devotes to our Poison Control System. However, no federal legislation to fund poison control services is pending and it would take a long time for federal legislation to work its way through to completion, if it could be passed.

FUTURE PAYMENT MATRIX

Payment Factor		Component / Function: POISON CONTROL SERVICES
Who is Paid?		Poison Control Services Contract Provider (currently University of California)
For What is payment made?		1. Public and provider access to poison advice and information via a single statewide toll-free telephone number and other media. 2. Increased Public education and poison prevention activities. 3. Development of clinical and telephone triage protocols for managing poisonings. 4. Data collection. 5. Hazardous materials incident planning and response advice. 6. Toxicology education and transference.
Who pays?		State General Fund pays $5.5 Million/year HMOs and other health insurers that use PCS and save on emergency patient care costs contribute $1 Million/ Year
When is payment made?		Varies
Why is payment made/needed? (Value)		Advice provided regarding poison exposures to parents, seniors, other individuals, and medical professionals, results in appropriate treatment of poison exposures and drug interactions, thus reducing death and disability. Frequently, advice allows safe treatment at home, thus avoiding unnecessary, costly visits to ER. Advice provided to public safety responders to Haz Mat incidents protects responders and public.
How is payment made?		State General Fund money is transferred from EMSA budget to PCS contractor. HMOs and other health insurers make contributions directly to PCS contractor.
Unmet Payment Needs		Consolidated PCC system costs $5.5 - $6 M/ year to operate. If the SGF provides $5.5 Million/ year and HMOs and other health insurers contribute $1 Million, the Poison Control System could increase poison prevention activities by $500 K to $1 M annually.
Other Info/ Comments		The current administration has sought, without success, funding for PCS from insurance companies and HMOs, which benefit financially from advice given to members to treat at home, thus avoiding costly ER visits. A concerted EMS effort would be required to convince them to contribute. A study of the expenditures and operations of the current system should be completed to determine if further consolidation would increase efficiencies.